CHRISTOPHER WAYNE LESTER

9 OF 14

MARKER-HOFF GROUP
THE LEADER IN PROFESSIONAL LITIGATION SUPPORT

STYLE OF CASE: Michael W. Harris, et al.

vs.

Purdue Pharma L.P., et al.

CASE NO: C-1-01-428

PERTAIN TO: Christopher Wayne Lester

FROM: Boone Homecare Supplies
327 State Street
Madison, WV 25130
(304) 369-7964

DELIVER TO: Mr. Phillip J. Smith
VORYS, SATER, SEYMOUR & PEASE, LLP
Atrium Two, Suite 2100
221 East Fourth Street
Cincinnati, OH 45202

THE ENCLOSED DOCUMENTS CAN BE IDENTIFIED BY NUMBERS 500688061-0001 THROUGH 500688061-0112.

Case No. **C-1-01-428**

Michael W. Harris	**: Southern District Court**
	:
vs.	**: County of Hamilton**
	:
Purdue Pharma L.P., et al	**: State of Ohio**

Records pertaining to: **Christopher Wayne Lester**

Custodian of Records For: **Boone Homecare Supplies**

I have conducted a thorough search of our files for the requested records, including but not limited to: patient intake forms and health questionnaires, and/or consent forms, and/or physical examination records, and/or x-rays, and/or pathology slides and/or blocks, and/or all nurses notes and physicians notes, and/or treatment records and reports, and/or prescription records, and/or third-party consultation records, and/or records of treatment at hospitals and other health care providers, and/or test results from outside laboratories, and/or itemized billing records, and/or insurance claims forms, and or personnel records and/or payroll records, and/or academic records, and/or correspondence.

I certify that nothing has been removed from the original file before releasing copies of these records or the originals. The records I am releasing are the original records or exact duplicates of the original records and include each and every record contained in the file on the above-named individual.

Kathleen S. Ellis
AFFIANT

Gloria J. Kitchen
WITNESS

August 25, 2003
DATE

437335

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE

NAME Christopher Lister

ADDRESS

CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1				
2				
3		5/ 03		
4		30 Caths # 8200		
5				
6		2 Leg Bags		
7				
8		1 Extension Tubing		
9				
10				
11		6/24/03		
12				
13		31 Caths # 8200		
14				
15		2 Leg Bags		
16				
17		1 Extension Tubing		
18				

Billed 6/30/03

RECEIVED BY

TAX

TOTAL

adams
25805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN SNYDER 00/00/00 00/00/00

59654

200046841

05/16/03	12	A4324 NU	55.00	30	
05/16/03	12	A4358 NU	14.00	02	
06/16/03	12	A4324 NU	55.00	30	
06/16/03	12	A4358 NU	14.00	02	

437335 138.00 0.00 138.00

Signature On File
06/30/03

5507390150

0

500688.061.0002

437334

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE

NAME Christopher Lester

ADDRESS

CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1		5/ 03		
2				
3	5	Bio-freeze		75.00
4				
5				
6		6/ 03		
7				
8	2	Nursing Care Ointment	3.75	7.50
9	1	Bio-freeze		15.00
10	2	Derma Lotion	9.00	18.00
11				
12				
13				40.50
14				
15		Chris Lester		
16		billed 6/30/03		
17				
18				

RECEIVED BY

TAX

TOTAL

adams
25805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN SNYDER 00/00/00 00/00/00

7242

2000046841

05/14/03	12	A4595 NU	75.00	02
06/14/03	12	A4595 NU	40.00	01

437334 115.00 0.00 115.00

Signature On File
06/30/03

5507390150

0

500688.061.0004

223385

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 1-16-03

NAME Christopher Lester 13785

ADDRESS [redacted] 3340

CITY, STATE, ZIP [redacted] -1971 DOT 03-10-2000

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RET'D.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	31	Catheters #8200		
2		A4354 NU	30	5.00
3	2	Leg Bags # 150102		
4		A4358 NU	2	14.00
5	1	Left tubing #9803		
6		~~A4357 NU 2 38.00~~		
7				
8				
9		596.54		
10				
11		Frederick C. Martine		
12				
13				
14		PA #20000416841		
15				
16				
17				
18				

RECEIVED BY Chris Lester

TAX

TOTAL

adams
05

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

FREDERICK C. MARTINE 00/00/00 00/00/00

59654

2000046841

01/16/03	12	A4324 NU	55.00	30
01/16/03	12	A4358 NU	14.00	02

223385 69.00 0.00 69.00

Signature On File
01/17/03

5507390150

0

500688.061.0006

727333

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 3-14-03

NAME Christopher Lester

ADDRESS [redacted] 3340

CITY, STATE, ZIP DOB [redacted] 1971 DOI 03-10-2000

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT
	1435						

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	33	#ELOAT Electrodes	33	00
2	1	Biofreeze	15	00
3	1	Battery	12	00
4	2	Tens Unit	15	00
5				
6		7242		
7		A4595 RU 2	75	00
8				
9		John Snyder		
10		[redacted]		
11		[redacted]		
12				
13				
14		Chris Lester		
15				
16				
17		RA# 2000046841		
18				

RECEIVED BY

TAX

TOTAL

adams
35805

A [redacted]6340

LESTER CHRISTOP X

[redacted]8340

P

X

X West Virginia Workers Comp.

X

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JOHN SNYDER 00/00/00 00/00/00

7242

2000046841

03/14/03 12 A4595 NU 75.00 02

727333 75.00 0.00 75.00

Signature On File
03/21/03

5507390150

0

500688.061.0008

10th

327819

DATE 6/4/03

NAME Christopher Lester

ADDRESS

CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1				
2				
3		Koo06 RRKJ		$110.00
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
RECEIVED BY			TAX	
			TOTAL	

Billed 6/19/03

35805

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
[redacted] 9969	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LESTER CHRISTOPHER	3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1971 SEX M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): LESTER APRIL	
5. PATIENT'S ADDRESS (No., Street): PO BOX 1113	6. PATIENT RELATIONSHIP TO INSURED: Self / Spouse / Child / Other
7. INSURED'S ADDRESS (No., Street): SAME	
CITY: DANVILLE STATE: WV	8. PATIENT STATUS: Single / Married / Other; Employed / Full-Time Student / Part-Time Student
CITY STATE	
ZIP CODE: 25053 TELEPHONE (Include Area Code): (304) 369-6657	
ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 7770	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES / NO X
a. INSURED'S DATE OF BIRTH MM DD YY SEX M / F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M / F	b. AUTO ACCIDENT? YES / NO X PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME: WAPETA	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES / NO X
c. INSURANCE PLAN NAME OR PROGRAM NAME: ACORDIA NATIONAL	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / NO If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: JOHN SNYDER	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES / NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 438.10 3. 780.39 2. 724.2 4.		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 06 04 03 06 04 03	12		K0006	RRKJ	1,2,3	110.00	30	days			
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X / NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
55-073-9015-001 X	327819		$ 110.00	$	$ 110.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Kathleen A. Ellis SIGNED DATE	06/19/03	(304) 369-7964 BOONE HOMECARE SUPPLIES 327 STATE STREET MADISON, WV 25130 PIN# 55-0739015,001 GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

500688.061.0010

727387

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 3-21-03

NAME Christopher Lester

ADDRESS [redacted] 3240

CIT [redacted] 1971 DOI 3-10-2000

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1				
2	1	Thermophore Moist Heating Pad E0215 NU	75.00	
3				
4		n242 [redacted]		
5				
6		[redacted]		
7				
8		Frederick Martino		
9				
10		Chi Lek Sweden		
11				
12				
13				
14		PA 20000 46841 RX		
15				
16				
17				
18				

RECEIVED BY

TAX

TOTAL

35805

500688.061.0011

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN SNYDER 00/00/00 00/00/00

7242

2000046841

03/21/03 12 E0215 NU 75.00 01

727387 75.00 0.00 75.00

Signature On File
04/23/03

5507390150

0

500688.061.0012

comp Q+h

727434

DATE 5-4-03

NAME Christopher Lester

ADDRESS

CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1				
2		Koode RROKS		110.00
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
	RECEIVED BY		TAX	
			TOTAL	

Billed 5/18/03

35805

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)	[redacted]-9969
2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LESTER CHRISTOPHER	3. PATIENT'S BIRTH DATE: [redacted] 1971 SEX: M X F
4. INSURED'S NAME (Last Name, First Name, Middle Initial): SAME	
5. PATIENT'S ADDRESS (No., Street): PO BOX 1113	6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other
7. INSURED'S ADDRESS (No., Street)	
CITY: DANVILLE STATE: WV	8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student
CITY STATE	
ZIP CODE: 25053 TELEPHONE (Include Area Code): (304) 369-6657	
ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:
11. INSURED'S POLICY GROUP OR FECA NUMBER: 7770	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES X NO
a. INSURED'S DATE OF BIRTH MM DD YY SEX M F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES X NO PLACE (State)
b. EMPLOYER'S NAME OR SCHOOL NAME: WAPETA	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES X NO
c. INSURANCE PLAN NAME OR PROGRAM NAME: ACORDIA NATIONAL	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE
d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE:

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SOR

14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: JOHN SNYDER	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE): 1. 438.10 2. 724.2 3. 780.39 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 05 04 03 05 04 03	12		K0006	RRKJ	1,2,3	110.00	30	days			
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
55-073-9015-001 X	727434	X	$ 110.00	$	$ 110.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Kathleen S. Ellis SIGNED DATE: 05/08/03		(304) 369-7964 BOONE HOMECARE SUPPLIES 327 STATE STREET MADISON WV 25130 55-0739015,001 GRP#

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

500688.061.0014

226415

DATE 2-4-04

NAME Christopher Lester

ADDRESS

CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

QUAN.	DESCRIPTION	PRICE	AMOUNT
1			
2	Rookie		$110.00
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
RECEIVED BY		TAX	
		TOTAL	

35805

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE / MEDICAID / CHAMPUS / CHAMPVA / GROUP HEALTH PLAN / FECA BLK LUNG / OTHER — (Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID) — X	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1) [redacted]9969	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) LESTER CHRISTOPHER	3. PATIENT'S BIRTH DATE MM DD YY [redacted]1971 SEX M X F	4. INSURED'S NAME (Last Name, First Name, Middle Initial) SAME
5. PATIENT'S ADDRESS (No., Street) PO BOX 1113	RELATIONSHIP TO INSURED Self Spouse X Child Other	7. INSURED'S ADDRESS (No., Street)
CITY DANVILLE STATE WV	8. PATIENT STATUS Single Married Other	CITY STATE
ZIP CODE 25053 TELEPHONE (Include Area Code) (304) 369-6657	Employed Full-Time Student Part-Time Student	ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER 7770
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO X	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F	b. AUTO ACCIDENT? YES NO X PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME WVAPEIA
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO X	c. INSURANCE PLAN NAME OR PROGRAM NAME NORDIA NATIONAL
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SOF

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE JOHN SNYDER	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. 438.10 3. 780.39 2. 724.2 4.		22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 04 04 03 04 04 03	12		K0006 RR		1,2,3	110.00	30	DAYS			
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. BALANCE DUE
55-073-9015--001 X	226415	X YES NO	$ 110.00	$	$ 110.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #
Kathleen S. Ellis SIGNED DATE	05/02/03	(304) 369-7964 BOONE HOMECARE SUPPLIES 327 STATE STREET MADISON WV 25130 55-0739015,001 PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

500688.061.0016

Certificate of Medical Necessity

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs
Division of Coal Mine Workers' Compensation

Completion of this form and prior approval is required for the Department of Labor to authorize reimbursement of charges for equipment, scheduled pulmonary rehabilitation services and home nursing care. Authorization covers a maximum period of one (1) year. Fill in all applicable items. (See DOL Reimbursement Standards under item eleven (11)). This form must be signed and dated by the treating physician.

OMB No.: 1215-0113
Expires: 10-31-99

1. & 2. Patient's Name and Mailing Address
CHRISTOPHER LESTER
PO BOX 1113
DANVILLE, WV 25053

3. Telephone Number
(304) 369 6657

4. Social Security Number
[redacted]-3340

5. Date of Birth
[redacted]-1971

6a. Date(s) of last hospitalization
From:
To:

6b. Condition(s) treated while in hospital

7. DIAGNOSIS for which this prescription is written:
Chronic Lung Disease

8a. Type of Prescription
[X] Original (New)
[ ] Recertification (Renewal)

8b. Requested Duration of Prescription for DME, Home Nursing or Pulmonary Rehabilitation
Beginning Date: 03-19-03
Ending Date: 03-19-04

9. EQUIPMENT OR SERVICE PRESCRIBED (SEE NO. 11, REVERSE, FOR CORRESPONDING REIMBURSEMENT STANDARDS)

9a. Oxygen Delivery Equipment (11b.) Prescription: Flow Rate (L/M) _____ Est. Hrs./Day _____

[ ] Tank O_2 With Flowmeter and Humidifier
[ ] O_2 Concentrator
[ ] O_2 Liquid System
[ ] Portable Unit (Gaseous)
[ ] O_2 Liquid System With Portable Liquid

9b. Other DME
[ ] Manual Hospital Bed (11c.)
[ ] Semi-electric Hospital Bed (11c.)
[ ] Nebulizer with Motor (11a.)
[ ] Commode (11f.)
[ ] Wheelchair (11g.)
[X] Other (Explain in Item no. 12.)

9c. Prescription for Medical Services
[ ] Pulmonary Rehabilitation Services (See 11e.)
Level: _____
[ ] Home Nursing Care (See 11d.)

10. Objective Test Results - Original or Certified copies of all lab reports must be attached, including tracing for each PFT. The following data (10A through 10D for a PFT; 10E through 10I for an ABG) MUST BE reported below OR on the attached lab report. (Note: Patient's condition is considered ACUTE if test was taken during a hospitalization.)

A. Pulmonary Function Test
Date of test: MM DD YY
Pt.'s condition: [ ] Acute [ ] Chronic
Results: (Best Effort)

	Predicted	Bronchodilation Before	Bronchodilation After
FEV 1 L/BTPS			
FVC L/BTPS			

B. Check as appropriate (if "poor", explain in No. 12 "Additional Comments")
Miner's Cooperation: [ ] Good [ ] Fair [ ] Poor
Miner's ability to understand instructions and follow directions: [ ] Good [ ] Fair [ ] Poor

C. Was equipment calibrated before the test? [ ] Yes [ ] No

D. Testing Facility Name and Address:

E. Arterial Blood Gas Test
Date of test: MM DD YY
Pt.'s condition: [ ] Acute [ ] Chronic
Results:

PO_2	PCO_2	PH

F. Air Intake: [ ] On room air [ ] On O_2 @ ____ LPM

G. Time Sample Drawn _____ Iced [ ] Yes [ ] No Time Sample Analyzed _____

H. Was equipment calibrated before the test? [ ] Yes [ ] No

I. Testing Facility Name and Address

Form CM-893
Rev. Dec. 1990

500688.061.0017

11. DOL/DCMWC REIMBURSEMENT STANDARDS

11a. **For nebulizer equipment with compressor motor:** requires Pulmonary Funciton Test results that indicate a 50% reduction with a demonstrated 10% or greater increase after bronchodilation; or FEV_1 of 1.0L or less (See 11h).

11b. **For Home O_2 delivery equipment:** requires a pO_2 value of 60 mmHg or less on room air during a chronic state with corresponding pCO_2 and pH values. The pO_2 value should be 55 mmHg or less when an O_2 concentrator or liquid O_2 system is prescribed. If the ABG is done while the patient is on O_2, the pO_2 standard = 60 mmHg for all oxygen equipment. (See 11h.). All medical evidence to support your request will be considered.

11c. **Hospital bed:** must be justified by PF test results indicating an FEV_1 equal to or less than 40% of predicted, or chronic hypoxia (pO_2 of 55 mmHg or less).

11d. **Prescriptions for home care:** must include objective test results or comparable clinical data, explanation why the patient is homebound, and a specific schedule of services to be rendered, including the total number and frequency of prescribed visits. Indicate the type of medical professional (PA, RN, LPN, RT) providing care. Use number 12, below, and/or attach separate sheet.

11e. **Prescription for pulmonary rehabilitation services:** must include objective test results that justify extent (i.e., level) of rehabilitation prescribed. All services for pulmonary rehabilitation must be categorized by Impairment Level (AMA - Guides to the Evaluation of Permanent Impairment, 2nd Ed. 1984). Also, all pulmonary rehabilitation protocols must be prior-approved. Use number 12, below, and/or attach separate sheet.

11f. **Commodes:** will be purchased for patients unable to use an available bathroom facility due to a pulmonary impairment. **Objective test requirements:** for ABG, pO_2 of 55 mmHg or less; for PFS, FEV_1 of 40% or less of predicted.

11g. **Wheel chairs:** are not a commonly covered item. Requests must include medical support data and will be evaluated individually. Data must support the wheelchair need because of a severe pulmonary impairment.

11h. **ALL CMN supportive test results:** must be dated 12 months or less prior to prescription for services. Recertification services must be reviewed yearly or at the expiration date.

NOTE: Prescription for indefinite services or those without required objective test data will be returned for specific information. If your request is rejected because your patient's medical condition does not meet DOL reimbursement requirement standards you may submit other medical evidence to support your prescription request. All evidence will be considered.

12. Comments:
E0215: MOIST HEATING PAD

13. PHYSICIAN/PROVIDER INFORMATION

a. Physician's Name, Address and Phone Number (print or type)
JOHN SNYDER
705 MADISON AVENUE
MADISON, WV 25130
(304) 369-5170

b. Are you the patient's regular physician or are you actively treating this patient? Yes ☑ No ☐

If NO, explain why you are prescribing the equipment or services on this form.

c. Date of Visit (the date you examined the patient and determined the need for this prescription): 3 / 16 / 09 (MM DD YY)

d. Date that the prescribed treatment or service is authorized to begin: 3 / 19 / 9 (MM DD YY)

e. By my signature I certify that I am actively treating this patient (or have provided an explanation, 13b., above) and that the prescribed equipment and/or services on this form are medically necessary for treating this patient's condition. I am also aware that, pursuant to 30 U.S.C. 941, any person who willfully makes any false or misleading statement or representation for the purpose of obtaining any benefit or payment relating to this prescription shall be guilty of a misdemeanor and subject to a fine and/or imprisonment.

Physician's Original Signature (Do not use stamp) — Date: 3-21-09

Please forward this completed form to the DOL/DCMWC Office which maintains the patient's Black Lung Claim. For further information call TOLL FREE: 1-800-638-7072. (In MD.: 1-800-492-5737)

f. Servicing Provider's Name, Address, Phone No., and PROVIDER NO.:
BOONE HOMECARE SUPPLIES PROVIDER#
327 STATE STREET 55-0739015-001
MADISON, WV. 25130 (304)369-7964

Public Burden Statement

We estimate that it will take an average of 20-40 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the Office of RIM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0113), Washington, D.C. 20503.
DO NOT SEND THE COMPLETED FORM TO EITHER OF THESE OFFICES

BOONE HOMECARE SUPPLIES
324 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

208677

DATE 1-16-03

NAME Christopher Lester

ADDRESS [redacted] 3340 #13786

CITY, STATE, ZIP [redacted] 1971 DOI 03-10-2001

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	5	Biofreeze @ 12.00		100.00
2				
3	8	Electrodes Disposable @ 1.00		8.00
4				
5	1	Tens Lotions		7.50
6		A4595 NU		
7		2-75.00		
8		John Snyder		
9				
10		724.2		75.50
11				
12		PA# 20000468411		
13				
14				
15				
16				
17				
18				
			TAX	
			TOTAL	

RECEIVED BY Chris Lester

adams
35805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN SNYDER 00/00/00 00/00/00

7242

2000046841

01/16/03 12 A4595 NU 75.00 02

208677 75.00 0.00 75.00

Signature On File
01/17/03

5507390150

0

500688.061.0020

MDCD 7th 708616

DATE 3-4-03

NAME Christopher Lester

ADDRESS

CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

QUAN.	DESCRIPTION	PRICE	AMOUNT
1			
2	Koodle RRRJ 1 - 100.00		
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
RECEIVED BY		TAX	
		TOTAL	

Billed 3/3/03

35805

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE	MEDICAID	CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
(Medicare #)	(Medicaid #)	(Sponsor's SSN)	(VA File #)	(SSN or ID)	(SSN)	X (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]9969

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LESTER CHRISTOPHER

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1971 SEX M X F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): LESTER APRIL

5. PATIENT'S ADDRESS (No., Street): PO BOX 1113

6. PATIENT RELATIONSHIP TO INSURED: Self Spouse X Child Other

7. INSURED'S ADDRESS (No., Street): SAME

CITY: DANVILLE STATE: WV

8. PATIENT STATUS: Single Married X Other; Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE: 25053 TELEPHONE (Include Area Code): (304) 369-6657

ZIP CODE TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 7770

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS): YES NO X

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO X PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: WVAPEIA

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO X

c. INSURANCE PLAN NAME OR PROGRAM NAME: ACORDIA NATIONAL

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SOF

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: JOHN M SNYDER

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 438.10 3. 780.39

2. 724.2 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER: 19605411

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 03 04 03 04 03 03	12		K0006	RR	1,2,3	110 00	30	DAYS			
2											
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN: 55-073-9015-001 X

26. PATIENT'S ACCOUNT NO.: 708516

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES X NO

28. TOTAL CHARGE: $ 110 00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 110 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Kathleen L. Ellis SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

03/13/03

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (304)369-7964

BOONE HOMECARE SUPPLIES
327 STATE STREET MADISON WV 25130

PIN# 55-0739015,001 GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

500688.061.0022

708272

6th

DATE 2-4-03

NAME Christopher Lester

ADDRESS

CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1				
2		Kodak PR 1-110.00		
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
RECEIVED BY			TAX	
			TOTAL	

Billed 2-03

35805

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE [ ] MEDICAID [ ] CHAMPUS [ ] CHAMPVA [ ] GROUP HEALTH PLAN [ ] FECA BLK LUNG [ ] OTHER [X]
(Medicare #) (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): [redacted]-9969

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LESTER CHRISTOPHER

3. PATIENT'S BIRTH DATE MM DD YY: [redacted]1971 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): LESTER APRIL

5. PATIENT'S ADDRESS (No., Street): PO BOX 1113

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [X] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): SAME

CITY: DANVILLE STATE: WV

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 25053 TELEPHONE (Include Area Code): (304)369-6657

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER: 7770

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME: WVAPEIA

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME: ACORDIA NATIONAL

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SOF

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: JOHN M SNYDER

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 438.10
2. 724.2
3. 780.39
4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER: 19605411

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 04 03	03 03 03	12		K0006	RR	1,2,3	110.00	30	DAYS			
2												
3												
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN: 55-073-9015-001 [ ] [X]

26. PATIENT'S ACCOUNT NO.: 708272

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 110.00

29. AMOUNT PAID: $

30. BALANCE DUE: $ 110.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Kathleen S. Ellis
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

02/04/03

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (304)369-7964

BOONE HOMECARE SUPPLIES
327 STATE STREET MADISON WV 25130
55-0739015,001

PIN# GRP#

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

500688.061.0024

208763

3rd - 5th

DATE

NAME Christopher Lester

ADDRESS

CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1		11/4/02		
2				
3		12/4/02 } Kodak RR 1-110.00		
4				
5		1/4/03 }		
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
	RECEIVED BY		TAX	
			TOTAL	

adams
35805

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
( ) (Medicare #) ( ) (Medicaid #) ( ) (Sponsor's SSN) ( ) (VA File #) ( ) (SSN or ID) ( ) (SSN) (X) (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
[redacted]-9969

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
LESTER CHRISTOPHER

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] 1971 SEX: M (X) F ( )

4. INSURED'S NAME (Last Name, First Name, Middle Initial)
LESTER APRIL

5. PATIENT'S ADDRESS (No., Street)
PO BOX 1113

6. PATIENT RELATIONSHIP TO INSURED: Self ( ) Spouse (X) Child ( ) Other ( )

7. INSURED'S ADDRESS (No., Street)
SAME

CITY: DANVILLE | STATE: WV

8. PATIENT STATUS: Single ( ) Married ( ) Other ( )

CITY | STATE

ZIP CODE: 25053 | TELEPHONE (Include Area Code): (304)369-6657

Employed ( ) Full-Time Student ( ) Part-Time Student ( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER
7770

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ( ) NO (X)

a. INSURED'S DATE OF BIRTH MM DD YY | SEX M ( ) F ( )

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX M ( ) F ( )

b. AUTO ACCIDENT? YES ( ) NO (X) PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME
WAPEIA

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES ( ) NO (X)

c. INSURANCE PLAN NAME OR PROGRAM NAME
ACORDIA NATIONAL

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ( ) NO ( ) If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SOF

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
JOHN M SNYDER

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ( ) NO ( ) $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. 438.10
2. 724.2
3. 780.39
4.

22. MEDICAID RESUBMISSION CODE | ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER
19605411

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 11 04 02	12 03 02	12		K0006	RR	1,2,3	110.00	30	DAYS			
2 12 04 02	01 03 03	12		K0006	RR	1,2,3	110.00	30	DAYS			
3 01 04 03	02 03 03	12		K0006	RR	1,2,3	110.00	30	DAYS			
4												
5												
6												

25. FEDERAL TAX I.D. NUMBER SSN EIN
55-073-9015-001 ( ) (X)

26. PATIENT'S ACCOUNT NO.
208763

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES (X) NO ( )

28. TOTAL CHARGE $ 330.00

29. AMOUNT PAID $

30. BALANCE DUE $ 330.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)
Kathleen S. Miller
SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)
01/22/03

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (304)369-7964
BOONE HOMECARE SUPPLIES
327 STATE STREET MADISON WV 25130
55-0739015,001
PIN# GRP#

PATIENT AND INSURED INFORMATION — CARRIER

PHYSICIAN OR SUPPLIER INFORMATION

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

500688.061.0026

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

333411

DATE 9-4-02

NAME Christopher Lester
ADDRESS 10/4/02
CITY, STATE, ZIP

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	1	Heavy Duty Wheelchair		
2		Invacare		
3		Tracer IV		
4		Bell Medical		
5		200-4503		
6		7242		
7		780.39		
8				
9		Billed		
10		10/24/02		
11				
12				
13				
14				
15				
16				
17				
18				
		RECEIVED BY April Lester	TAX	
			TOTAL	

adams 25805

Rental to
Purchase
10 Mths
Ref.
19605411

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE (Medicare #)	MEDICAID (Medicaid #)	CHAMPUS (Sponsor's SSN)	CHAMPVA (VA File #)	GROUP HEALTH PLAN (SSN or ID)	FECA BLK LUNG (SSN)	OTHER (ID)	1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
						X	[redacted]-9969

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)	
LESTER CHRISTOPHER	[redacted] 1971 M X F	LESTER APRIL	
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)	
PO BOX 1113	Self Spouse X Child Other	SAME	
CITY / STATE	8. PATIENT STATUS	CITY / STATE	
DANVILLE WV	Single Married Other		
ZIP CODE / TELEPHONE (Include Area Code)	Employed Full-Time Student Part-Time Student	ZIP CODE / TELEPHONE (INCLUDE AREA CODE)	
25053 (304) 369-6657		( )	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER	
		7770	
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F	
b. OTHER INSURED'S DATE OF BIRTH MM DD YY / SEX M F	b. AUTO ACCIDENT? YES NO PLACE (State)	b. EMPLOYER'S NAME OR SCHOOL NAME	
		WVAPEIA	
c. EMPLOYER'S NAME OR SCHOOL NAME	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME	
		ACORDIA NATIONAL	
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. RESERVED FOR LOCAL USE	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.	

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SOF

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)	15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	17a. I.D. NUMBER OF REFERRING PHYSICIAN	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
JOHN M SNYDER		
19. RESERVED FOR LOCAL USE		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)		22. MEDICAID RESUBMISSION CODE / ORIGINAL REF. NO.
1. 438.10 3. 780.39		23. PRIOR AUTHORIZATION NUMBER
2. 724.2 4.		19605411

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 09 04 02 10 03 02	12		K0006	RR	1,2,3	110.00	30	DAYS			
2 10 04 02 11 03 02	12		K0006	RR	1,2,3	110.00	30	DAYS			
3											
4											
5											
6											

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE	29. AMOUNT PAID / 30. BALANCE DUE
55-073-9015-001 X	333411	X YES NO	$ 220.00	$ $ 220.00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)	33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # (304)369-7964
Kathleen S. Ellis SIGNED DATE	10/24/02	BOONE HOMECARE SUPPLIES 327 STATE STREET MADISON WV 25130 55-0739015,001 PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) PLEASE PRINT OR TYPE FORM HCFA-1500 (12-90) FORM OWCP-1500 FORM RRB-1500

500688.061.0028

Today's Date : 12/05/2002

Patient Account Number :

Patient Name : CHRISTOPHER W LESTER

Ratient HICN : [redacted]3340A Patient DOB : [redacted]/1971

PO BOX 1113
DANVILLE WV 25053 Patient Phone : (304) 369-6657

Diagnosis Codes: 1) 724.2 2) 780.39 3) 4)

Supplier's Medicare #: 0956640001

Ordering Provider Info : E13868 JOHN SNYDER

From DOS	To DOS	POS	Units	HCPCS	Mods	DX	Charge	CMN
09/04/02	09/04/02	12	1.0	K0006	RRKH	1	110.00	Y
10/04/02	10/04/02	12	1.0	K0006	RRKI	1	110.00	
Totals :							220.00	

13378

Billed
12-6-02

523675

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 12/9/02

NAME Christopher Baxter
ADDRESS [redacted] 3340 13555
CITY, STATE, ZIP [redacted] 1971

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	30	Catheters # 8200 A4358	UU	55.00
2	2	leg bags A4358	UU	14.00
3	2	urine drain bags A4357	UU	2.000
4	1	ext tubing		
5				
6		03102000 A4324		
7				
8				
9				
10		Frederick C Martinc		
11				
12		596054		
13				
14		2000046841		
15				
16				
17				
18				
RECEIVED BY			TAX	
			TOTAL	

adams 25805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

FREDERICK C MARTINE 00/00/00 00/00/00

59654

2000046841

12/09/02	12	A4324 NU	55.00	30
12/09/02	12	A4358 NU	14.00	02
12/09/02	12	A4357 NU	20.00	02

523675 89.00 0.00 89.(

Signature On File
12/20/02

55073901

0

500688.061.0031

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

523719

DATE 12/9/02

NAME Christopher Lester

ADDRESS [redacted] 3340 13554

CITY, STATE, ZIP [redacted] -971

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	1	Leak wiper		24 00
2	1	Battery		12 00
3	3	Bio Freeze @ 12.00		36 00
4				
5		03102000		72 00
6		John M Snyder		
7	3	Patches 1.00		3 00
8				
9		1242 Chris Lester		75 00
10				
11				
12				
13		20006 46841		
14				
15		A4595 NU 2-75.00		
16				
17				
18				
	RECEIVED BY		TAX	
			TOTAL	

adams
25805

523673

BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
PHONE (304) 369-7964

DATE 12/09/02

NAME Christopher Lester
ADDRESS [redacted] 3340
CITY, STATE, ZIP [redacted] 971

ORDER NO.	SOLD BY	CASH	C.O.D.	CHARGE	ON ACCT.	MDSE. RETD.	PAID OUT

	QUAN.	DESCRIPTION	PRICE	AMOUNT
1	3	lotion #UP237N @ 7.50		22.50
2	4	Electrodes #643 @12.00		48 00
3	4	Patches @ 1.00		4 00
4				
5		03102000		75 00
6		John M Snyder		
7				
8				
9				
10				
11				
12		7242		
13				
14		2000046841		
15				
16				
17		A4595 UU 2-75 00		
18				
RECEIVED BY			TAX	
			TOTAL	

adams
25805

X [redacted]3340

LESTER CHRISTOP X

[redacted]3340

P

X

X West Virginia Workers Comp.

X

00000000

JOHN M SNYDER 00/00/00 00/00/00

7242

2000046841

11/09/02	12	A4595 NU	75.00	02
12/09/02	12	A4595 NU	75.00	02

523719 150.00 0.00 150.00

Signature On File
12/20/02

5507390150

0

500688.061.0034

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0679

CERTIFICATE OF MEDICAL NECESSITY

DMERC 02.03B

MANUAL WHEELCHAIRS

SECTION A — **Certification Type/Date:** INITIAL 9/4/02 REVISED / /

PATIENT NAME, ADDRESS, TELEPHONE and HIC NUMBER
CHRISTOPHER LESTER
PO BOX 1113
DANVILLE, WV 25053
(304) 369-6657 HICN

SUPPLIER NAME, ADDRESS, TELEPHONE and NSC NUMBER
BOONE HOMECARE SUPPLIES
327 STATE STREET
MADISON, WV 25130
(304) 369-7964 NSC # 0956640001

PLACE OF SERVICE 12
NAME and ADDRESS of FACILITY if applicable (See Reverse)

HCPCS CODE
K0006

PT DOB [redacted]71 Sex M (M/F): HT. 68 (in.): WT. 300 (lbs.)

PHYSICIAN NAME, ADDRESS, TELEPHONE and UPIN NUMBER
JOHN M SNYDER
705 MADISON AVENUE
MADISON, WV 25130
304-369-5170 UPIN # B13868

SECTION B — **Information in This Section May Not Be Completed by the Supplier of the Items/Supplies.**

EST. LENGTH OF NEED (# OF MONTHS): 99 1-99 (99=LIFETIME) DIAGNOSIS CODES (ICD-9): 438.10 729.2

ITEM ADDRESSED	ANSWERS	ANSWER QUESTIONS 1, 5, 8 AND 9 FOR MANUAL WHEELCHAIR BASE, 1-6 FOR WHEELCHAIR OPTIONS/ACCESSORIES. (Circle Y for Yes, N for No, or D for Does Not Apply, unless otherwise noted.)
Manual Whichr Base And All Accessories	(Y) N D	1. Does the patient require and use a wheelchair to move around in their residence?
Reclining Back	Y (N) D	2. Does the patient have quadriplegia, a fixed hip angle, a trunk cast or brace, excessive extensor tone of the trunk muscles or a need to rest in a recumbent position two or more times during the day?
Elevating Legrest	Y (N) D	3. Does the patient have a cast, brace or musculoskeletal condition, which prevents 90 degree flexion of the knee, or does the patient have significant edema of the lower extremities that requires an elevating legrest, or is a reclining back ordered?
Adjustable Height Armrest	Y (N) D	4. Does the patient have a need for arm height different than that available using non-adjustable arms?
Reclining Back; Adjustable Ht. Armrest; Any Type Lwt. Whichr	4	5. How many hours per day does the patient usually spend in the wheelchair? (1-24) (Round up to the next hour)
Any Type Lwt. Whichr	(Y) N D	6. Is the patient able to adequately self-propel (without being pushed) in a standard weight manual wheelchair?
Any Type Lwt. Whichr	(Y) N D	9. If the answer to question #8 is "No," would the patient be able to adequately self-propel (without being pushed) in the wheelchair which has been ordered?

NAME OF PERSON ANSWERING SECTION B QUESTIONS, IF OTHER THAN PHYSICIAN (Please Print):
NAME: JOHN MSN TITLE: EMPLOYER:

SECTION C — **Narrative Description of Equipment and Cost**

(1) Narrative description of all items, accessories and options ordered; (2) Supplier's charge; and (3) Medicare Fee Schedule Allowance for each item, accessory, and option. *(See instructions on back.)* If additional space is needed, list wheelchair base and most costly options/accessories on this page and continue on HCFA Form 854.

K0006: HEAVY DUTY WHEELCHAIR
$110.00 MONTHLY RENTAL
$106.07 MEDICARE MONTHLY RENTAL

☐ CHECK HERE IF ADDITIONAL OPTIONS/ACCESSORIES ARE LISTED ON ATTACHED HCFA FORM 854

SECTION D — **Physician Attestation and Signature/Date**

I certify that I am the treating physician identified in Section A of this form. I have received Sections A, B and C of the Certificate of Medical Necessity (including charges for items ordered). Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information in Section B is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE [signature] DATE 9/12/02 (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

FORM HCFA 844 (5/97)

RECEIVED SEP 12 2002

500688.061.0035